Bureau of Quality Improvement Services (BQIS)

Mortality Communication

BQIS

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Mortality Communication Purpose

- It is the expectation of BQIS that providers will familiarize themselves (and staff) with this information through training efforts.
- The following issues were identified during mortality reviews completed during the first quarter of fiscal year 2013 (July through September 2012).
- While the data presented may pertain to comorbid conditions that are not attributable to the cause of death, the risk involved with these conditions warrant further examination.
- This communication is not intended to provide specific medical recommendations and interested parties should seek further clarification from trained medical professionals.

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

Hospital Discharge Summary

A hospital discharge summary is a narrative document (written and signed by a physician) that focuses on many aspects of hospitalization important to follow up care by the primary care provider (PCP). The audience of the hospital discharge summary is a health care professional or facility with health care expertise (e.g., PCP, hospital consultants, rehabilitation or nursing home personnel, home health agency, etc.). This may not be readily available at the time of discharge but may be available soon thereafter or within one or more days after discharge. The technical medical information summarized, the follow up appointments, the complete medication regimen, the recommended clinical management, and the lab test results as well as tests with results still pending are important to a smooth post hospital follow through by the PCP's office or other health care setting. The hospital discharge summary is different than the hospital forms (often hand written or edited) given to the person/support staff/Interdisciplinary Team (IDT) at the time of discharge that focus on **patient discharge instructions** and information that assists in assuring a smooth transition to the home. This is usually written in lay terms and may be accompanied by handouts for the major diagnoses, to assist the person and support staff in understanding the condition(s).

At times, handouts regarding diagnoses are provided along with the discharge instructions to assist with caregiver education of the diagnosis/illness. These handouts are valuable and written in lay terms. If the discharge instructions do not include handouts regarding the diagnoses, the nurse (or other designated person) may need to research each of the listed diagnoses for signs and symptoms and present that information in lay terms to the direct support professional (DSP), so the staff know what to look for and when to notify the nurse. A risk plan should be developed for each major diagnosis, especially for those diagnoses listed in the Individual Support Plan (ISP) or ISP addendum, and for which training of staff is indicated for successful treatment of the diagnosis. For instance, a new placement of a feeding tube requires a consumer-specific risk plan for a feeding tube – from formula administration, to prevention of dislodging and clogging of the tube.

What are some of the components of patient discharge instructions? Discharge instructions include several potential components, including the medications prescribed at the time of discharge, the length of time prescribed (for instance, 10 days for antibiotics, or continuous until follow up with the PCP for long term medication use), the dosage strength, frequency and route (e.g., by mouth, by g-tube, etc.), the time of day the last dose of each medication was administered, as well as any change in diet and follow up appoint-

Hospital Discharge Summary (cont)

ments with specialists, or any follow up tests that are recommended (chest x-ray, magnetic resonance imagery [MRI], etc.). Some information that may be important to the provider or agency nurse might not be written on the discharge sheets and may need to be requested, such as the last weight with date of the weight (if applicable to ongoing post hospital care), the number of seizures that occurred in the hospital, days of the seizures, and duration of seizures (important for recording in the seizure log at the home), any falls or injuries during the hospitalization (important when bruises are identified after arriving home, for instance), names and office phone numbers of consultants (if applicable), whether any vaccinations were administered in the hospital (to update the vaccination record and ensure that vaccinations are not repeated), etc.

While teams might see some variation in the title of the document, the components of the hospital discharge summary and the patient discharge instructions provide the essential information for a successful transition.

Both documents are important to the people (e.g., DSP staff, the nurse or designee, etc.) involved in the care in the home.

Some of the components are especially important for the nurse to review and incorporate into risk plans and complete staff training. These include:

- **A chronological order of events and, in summary form, documentation of the major findings and events leading up to date of discharge.** This information provides the needed background for the nurse (or other appropriate person) to write a health care/ risk plan. The hospital discharge summary provides the background for the discharge instructions (e.g., the reason an antibiotic is prescribed, the reason for cardiac medication, the reason for the adaptive equipment, etc.), and includes a list of final diagnoses. The hospital discharge summary provides the context for the diagnosis in the series of events at the hospital.

- **Any allergies/adverse effects to any medications given in hospital.** It will be important to include these on the Medication Administration Record located in the home.

- **A list of the consultants/specialists who were utilized during the hospitalization** (e.g., specialties that may not have been previously required) may be included in the narrative and/or listed separately. In some situations, the person may require follow up (may be part of discharge instructions) and in other cases the person may not need follow-up with the specialist (would not be part of the discharge instructions). However, if the person has a similar problem in the future, since the consultant now knows the person and the person is an established patient, for the purposes of continuity of care, this would be the consultant to whom a future referral may be made.

- **Information regarding any procedures and/or treatments performed** (e.g., modified barium swallow study (MBSS), etc.). A copy of the results of any procedures should be obtained for future reference. This may need to be requested separate from a discharge summary or any discharge instructions. If the procedure is done early in the hospitalization, a copy of the results would benefit the IDT as to whether the home can continue to care for the person, or if the person would be better placed temporarily or permanently in an alternative setting. It may also provide information so that a risk plan can be developed and staff trained ahead of time prior to the person's return home. For instance, an MBSS may indicate the need for a pureed diet with nectar thick liquids, when the person had been on a regular diet prior to hospitalization. Training can be provided in preparation for the person's return. A copy of the procedural results allows the nurse to determine whether the test procedure was completed successfully, or needs to be repeated at some interval. For instance, an MBSS completed with a person who is not cooperative may only provide partial results, and may need to be rescheduled. A colonoscopy procedure note may indicate inadequate bowel preparation and a recommendation from the gastroenterologist to repeat the procedure with a specific bowel preparation or defer the procedure until an office visit, when there can be further discussion with the family/guardian, and/or support staff, etc. This information assists the nurse (or other designated person) with ensuring diagnoses/aspects of care are not overlooked. If a certain test/procedure was completed in the hospital and was previously scheduled as outpatient, then the QDDP (or other designated person) may need to discuss with the PCP whether the test needs to be repeated or if it should be cancelled.

- **The list of discharge diagnoses** provides guidance to the nurse (or other designated person) in the important areas needing observation.

- **Patient and caregiver instructions** are provided as part of the narrative of the summary, and provide an overview of any changes in medication regimens to be completed following discharge, with a summary of orders for therapy, diet, and follow up visits. As part of the hospital discharge summary, these discharge plans are a capsule summary of information that provides the necessary information to the community health care provider for awareness and follow up action.

Ensuring the information noted in the above components is provided in written form upon discharge from the hospital is important and can be used as a reference to ensure the same information is transferred to all documents in the home requiring this information.

Hospital Discharge Summary (cont)

When there are several new medications prescribed, the nurse or home manager may request the local pharmacy to review the list to ensure that there is not duplication of medication administration due to generic versus brand name medications.

As noted in Table 1, there have been 199+ in-patient hospitalizations for medical reasons reported each month. In addition, there have been between 38-74 in-patient hospitalizations for psychiatric reasons reported each month. A discharge summary and patient discharge instructions should have been obtained for each of these admissions to review, incorporate into risk plans, and conduct staff training.

Table 1. Number of In-patient Hospitalizations – Medical and Psychiatric (all funding sources) (from incident data)

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
In-patient Hospitalization - Medical	217	216	221	242	229	241	251	232	199	228	240	213
In-patient Hospitalization - Psychiatric	59	38	43	71	60	60	63	59	74	64	53	40

Resources:

- *Several fact sheets regarding hospitalization discharge are available on the BQIS web site - http://www.in.gov/fssa/ddrs/3948.htm*
- *http://imweb.swmed.edu/residency-program/365-discharge-351.html*
- *http://www.acphospitalist.org/archives/2009/03/discharge.html*

Choking Prevention

A number of choking deaths have occurred in settings outside the home (e.g., workshop, special events, day programming, community outings, restaurants, home visits, etc.). The agency needs to ensure that consumer-specific dining plans are available, competency-based training has been completed, there is sufficient supervision and plans are implemented correctly at all sites. A copy of the dining plan and any adaptive equipment (e.g., utensils, cups, dycem mat, blender, etc.) should be available whenever the person is eating or drinking whether it is mealtime, during a snack or during medication administration. If there is insufficient supervision to provide the necessary supports to ensure health/safety, the IDT needs to review the setting and the supports that can be provided by the home to ensure implementation of the dining plan. If the dining plan cannot be implemented correctly, steps need to be taken before allowing eating/drinking in that setting.

There are many reasons a person might be considered an unsafe eater. If it is a behavior, the dining plan may include verbal or physical cues to slow down the rate of eating (e.g., place the utensil on the table between bites, use the napkin to wipe mouth/chin, take a sip of liquids between bites, present the food in smaller portions (plate to plate method) to assist with taking smaller bites, etc.), chew more thoroughly, and/or not to talk/laugh with food/liquids in the mouth.

Another situation when a person might be considered an unsafe eater is when a person with an intellectual or developmental disability (IDD) is blind. The agency needs to ensure consistency in presentation of the food. Regardless of the staff or setting, the food should be presented in the same diet texture (e.g., chopped, pureed, cut in the same size of bite, etc.), same degree of dryness/amount of sauce or gravy, etc.), the food should be placed on the plate/tray in the same location, the cup should be filled to the same level each time and placed on the table/tray in the same location, and the person should be assisted if food or liquid is spilled. Consistency of presentation is essential. Attention should be provided to the person's positioning at the table. The person should not be left unattended to ensure correct bite-size pieces are ingested and that spilled food or liquid does not cause the person to fall from the chair in search of the item or glass. The local associations that specialize in assisting the blind may be

Choking is the inability to breathe because the trachea is blocked, constricted, or swollen shut. Choking is a medical emergency. When a person is choking, air cannot reach the lungs. If the airways cannot be cleared, death follows rapidly.

Choking Prevention (cont.)

beneficial to the IDT in improving both the independence and safety of the person.
An individual with dementia is also at risk of being an unsafe eater. For instance, the associated forgetfulness may not allow him/her to recall the need to cut food into bite-size pieces, to chew completely, or to swallow without prompts. The swallowing function can deteriorate slowly, as in Alzheimer's disease, or rapidly, as in a stroke. Staff need to be within view or at tableside for appropriate supervision and observation of the person because there may be no other obvious warnings of functional decline except swallowing difficulties.

Another situation is that if a person has a history of repeated pneumonia or aspiration pneumonia he/she may have a component of dysphagia. There may also be a component of gastroesophageal reflux disease (GERD) in which stomach acid/contents are aspirated. In such instances, direct supervision is appropriate to ensure proper positioning at all times during dining, to ensure there is no distraction while eating, and to observe for dysphagia triggers. This may lead to further evaluation/consultation.

It is imperative that staff have knowledge of the triggers of dysphagia, so they can observe and report such findings in a timely manner.

If someone chokes, regardless of whether the Heimlich or back blow is given or if the person recovers spontaneously, that information should be shared with all shifts for at least 24 hours. In addition, the nurse and the on–call home manager should be notified.

As part of the agency's review of the choking incident, the agency should obtain written details (e.g., item of food/liquid that caused the event, any actions (Heimlich, back blow, etc.) taken, etc.) of the event from the staff on duty at the time of the choking episode.

In addition, the response from the nurse, on-call staff and home manager/supervisor should be documented. Any relevant documentation should be reviewed to ensure completeness and accuracy (e.g., does the intake log indicate the person ate 100% of the meal when in actuality, the person went to the ER at the beginning of the meal?). The person should be monitored for signs/symptoms of aspiration via vital signs by trained staff for at least seven days following the choking episode. The results of any ER visit, urgent care visit, etc. along with any test results should be reviewed and appropriate actions taken.

Regardless of the last time a swallow study was obtained, if triggers develop, this may indicate the need for further review. Documentation of the triggers should be complete and accurate, and reviewed with the PCP. A bedside/chairside swallow assessment may be conducted by a speech therapist, in the home or other setting, or a modified barium swallow (MBS) may be ordered. In either case, it is important to have familiar staff present during the assessment/study in order to provide interpretation of vocalizations and gestures, share knowledge about proper positioning during meal times, assist the person with cooperating with the study, and increase the likelihood that the results of the tests are accurate.

For a person with a functional decline, serial studies may be indicated to ensure health and safety. Whenever triggers occur, the IDT needs to evaluate the need for a repeat evaluation. For someone with silent aspiration and few to no triggers, the speech therapist and PCP would provide the needed guidance in this aspect of care.

The data related to choking episodes is presented in two different ways in Tables 2 and 3. Choking episodes that required intervention (e.g., Heimlich, back blow, etc.) are presented in Table 2. The number of choking episodes when a person cleared his/her airway independently are not included in Table 2. The IDT should still discuss the episode, ensure a choking prevention plan is in place, and train staff. The number of deaths related to choking is presented in Table 3.

Table 2. Choking Episodes Requiring Intervention (all funding sources) (from incident data)

Description	2Q FY11	3Q FY11	4Q FY11	1Q FY12	2Q FY12	3Q FY12	4Q FY12	1Q FY13
Choking requiring Intervention	49	51	43	55	65	43	72	55

Table 3. Choking Deaths Due to Choking (all funding sources) (from mortality data)

Description	2Q FY11	3Q FY11	4Q FY11	1Q FY12	2Q FY12	3Q FY12	4Q FY12	1Q FY13
Death due to choking	2	2	0	2	6	0	7	1

Choking Prevention (cont.)

Providers should review their agency's policy/procedure regarding consumer-specific choking prevention/risk plans to ensure necessary proactive as well as reactive measures are included.

Each provider's policy/procedure should include a component regarding regular observation of mealtime, snack time and medication administration to ensure the choking prevention risk plan is being implemented as written.

Resources:

- *http://www.in.gov/fssa/files/Mortality_12.27.11.pdf*
- *http://www.in.gov/fssa/files/Choking_Checklist.pdf*
- *http://www.in.gov/fssa/files/Morality_Communication_7_9_12.pdf*
- *http://www.in.gov/fssa/files/Quarterly_Report_MR_1.31.12.pdf*
- *A training video on basic diet texture preparation is available at: http://www.youtube.com/watch?v=IvlAKZenBos*

Maintaining a Comprehensive and Accurate Medical History

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

This quarter's focus includes the following:

In preparation for a PCP visit, consultation with a specialist, hospitalization, ER visit, or urgent care center visit, the home should from create a packet of information that can be taken with the person to the visit. This would include an updated list of diagnoses, a list of prior surgeries with dates of surgeries if available, a list of current medications, dosages, frequency and route, the current diet (including texture of solids and thickening of liquids), any allergies to medication and the reaction if known, as well as the dates of hospitalizations (with primary diagnosis leading to hospitalization), ER visits, urgicare visits, and specialty consults. A list of specialty consultants that had been used in the past would assist in referring to that specialist should a problem occur which needs to be followed by a specialist with expertise in that area.

Any advance directive, a copy of the Power of Attorney/guardianship, and DNR decision that may have been completed would be important additional information.

It is also important that abbreviations not be used or used sparingly. For instance it is important to write out 'g tube' as gastrostomy tube and 'j tube' as jejunostomy tube, to reduce misinformation in a busy ER. Similarly, with poor legibility, some abbreviations appear similar and instead should be written out. For instance, PVD should be written as peripheral vascular disease and PUD as peptic ulcer disease.

When a person transitions to another provider, the comprehensive medical history is a vital document to share with the new provider prior to the transition date. This document will assist the provider in ensuring risk plans are in place and staff are trained.

Each provider should review (and update as appropriate) their policy/procedure to ensure guidance is provided to the IDT on which member of the IDT is assigned the responsibility for updating this information in a timely manner and the agency's progress for sharing the person's cumulative medical history with the PCP, specialist, emergency room, etc. The policy/procedure should also address the need for the information to be readily available in the home, and that all staff know the location of the packet. There should be a QA component to the policy/procedure regarding a system of ensuring compliance with the agency's policy/procedure.

Resources:

- *http://www.in.gov/fssa/files/Health_Record_Carey_Serv_OR-FN-HS-MA-34(11-9-09).pdf*
- *http://www.breckinridgemedicine.com/res/files/10/Medical%20History%20Forms.pdf*
- *http://www.acep.org/content.aspx?LinkIdentifier=id&id=26278&fid=896&Mo=No&acepTitle=Medical%20Forms*
- *http://www.in.gov/fssa/files/Comprehensive_Healthcare_Assessment_for_Persons_with_Disabilities_OR-FN-HS-HA-18(11-9-09).pdf*

During this annual review period (10/01/2011 – 09/30/2012), there were 46 allegations that a person was not having their medical needs met. Through the process of a complaint investigation conducted by BQIS, it was determined that 56.8% of these allegations were substantiated.

Health Care Coordination

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

There may be times a person has gone to an urgent care center or an ER, but the recommendations may not have been helpful in guiding care or in determining the cause for the change in health status. In such instances the home supervisor, nurse, or QDDP needs to provide additional guidance to the home staff. With promptness, the supervising/clinical staff should determine the concerns and ensure all documentation is current (e.g., vital signs, weights, pulse oximetry readings if applicable, seizure log is updated if applicable, bowel management log is updated if applicable, intake/output data is available, blood glucose readings are current, etc.). A call to the PCP or the on-call counterpart/specialist for that particular problem may provide guidance. It may be important to request the PCP or specialist to examine the person in the emergency room (ER) or other site or request other options. A second opinion in the same ER, or another hospital ER may be indicated. The team should continue to advocate for the person in order to seek answers until the person is stabilized. The packet of information described above should be updated and brought with the person. An urgent care center or initial ER visit may not be successful if insufficient information accompanied the person. If a second visit is needed, a staff familiar with the concerns, preferably a nurse, as well as a staff familiar with the gestures, body language and vocalizations of the person, would be imperative in order to have a quality evaluation.

Resources:

- *http://www.in.gov/fssa/files/Vital_Sign_Recording_Form_OR-FN-HS-VS-56(11-9-09).pdf*
- *http://patients.about.com/od/yourdiagnosis/a/failurediagnose.htm*
- *http://patients.about.com/od/misdiagnosis/ss/Mystery-Diagnosis-How-To-Solve-Your-Undiagnosed-Medical-Disease-Or-Condition.htm*

Purpose / Role of the Ombudsman

Through review of mortality packets and subsequent discussion, there are times when it might have been beneficial for the interdisciplinary team to utilize the services of the Ombudsman.

The role of the statewide waiver ombudsman is to receive, investigate and attempt to resolve complaints and concerns that are made by or on behalf of individuals who have a developmental disability and who receive HCBS waiver services. As such, they are in a position to advocate for the consumer.

Complaints intended for the Ombudsman may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral.

CONTACT:
Brian Reynolds
Developmental Disability Waiver Ombudsman
Division of Disability & Rehabilitative Services
Brian.Reynolds@fssa.in.gov
1-800-622-4484

Types of complaints received include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, and complaints requiring coordination between legal services, operating agency services and provider services.

The statewide waiver ombudsman coordinates his or her activities among the programs that provide legal services for individuals with a developmental disability, the operating agency, providers of waiver services, and providers of other necessary or appropriate services, and ensure that the identity of the participant will not be disclosed without either the participant's written consent or a court order.

Purpose / Role of the Ombudsman (cont.)

At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.

BQIS may also receive complaints and conduct investigations in situations where it appears consumers may not be treated appropriately. Cases that are directed to BQIS typically involve allegations of provider misconduct or deficiency. Following complaint investigations conducted by BQIS, substantiated allegations trigger corrective action requiring further verification. If a provider or other stakeholder has a question about who should receive a specific complaint, they are encouraged to enquire through the BQIS Help Desk (BQIS.Help@fssa.IN.gov).

To file a formal complaint associated with provider misconduct or deficiency, this can be through one of the following ways:

PHONE: *Complaint Hotline toll-free at (866) 296-8322*
FAX: *(484) 434-1541*
EMAIL: *BQIS.Help@fssa.in.gov*
MAIL: *Liberty of Indiana Corporation*
Attn: Complaints
440 N. Meridian St., Ste. 200
Indianapolis, IN 46204

Documentation Standards

Documentation

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases recently reviewed, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

This quarter's focus includes the following:

During review of submitted documents, it has been noted that documentation regarding the consistency of liquids (and foods) given is not as complete as it should be. For example, if a person is to receive nectar-thick liquid, the documentation should include the fact that the liquid given was thickened to nectar-thickness. Documentation should say "nectar-thick broth given" instead of just saying, "broth given."

Another example is when a person has a G-/J-tube. The Medication Administration Record (MAR) should specify the route (e.g., via g -tube, by mouth (po), etc.) for administering each specific medication.

Documents should be dated (month, day and year) with the date they were created (and/or reviewed/revised). This would include risk plans and staff training records. Without being dated, it is not known when a risk plan was in effect, if it was revised to address additional risk factors, and what version of a plan staff were trained on. Along the same lines, if training records are not dated, it is unclear as to the date when the training actually occurred.

Part of any agency's training for support staff include documentation standards. One of the basics is the requirement of not charting ahead of time (pre-charting). There have been recent reviews where this has been noted to have occurred.

It is suggested that agency administration ensures appropriate policies/procedures address the above issues, train staff on these issues, and have a system to monitor for compliance.

From examination of complaint investigations conducted from 10/01/2012 through 09/30/2012, 33 allegations of incomplete or inadequate documentation were reported and 92.6% substantiated.

Resources:

- *http://www.in.gov/fssa/files/MR_Quarterly_Report_10_6_11.pdf*

A review of diagnoses (including a history of or presence of decubitus) is a part of the mortality review process. The Mayo Clinic's definition of decubitus is (also called pressure sores or pressure ulcers) ***injuries to skin and underlying tissues that result from prolonged pressure on the skin. Bedsores most often develop on skin that covers bony areas of the body, such as the heel, ankles, hips or buttocks.*** *Individuals that are bedridden chronically from a stroke or paralysis are high risk for this condition, as well as those undergoing severe acute illness that requires bed rest for prolonged periods of time (sepsis).*

Prevention of and Treatment of Decubitus

A decubitus ulcer became a reportable incident as of 3/1/2011. While the number of decubitus ulcers reported are not high (Table 4), the person's quality of life is affected. There have been occasions when a person has had recurrence of decubitus.

If a person has a diagnosis of decubitus, it is important that the team aggressively address any issues that might have been contributing factors and remain diligent in preventing recurrence. Staff training and timely monitoring of the effectiveness of the plan are vital. In the event the current provider is not able to provide the necessary supports/services to prevent and/or treat for decubitus, the team should timely pursue and obtain alternative placement in a setting that can provide the necessary supports/services.

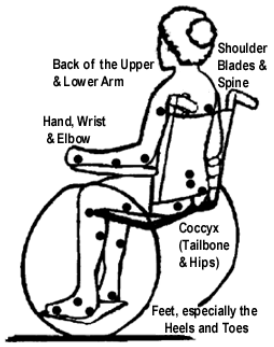
Table 4. Number of Decubitus Ulcers Reported (all funding sources) (from incident data)

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Decubitus ulcer	10	9	9	7	14	9	9	17	10	10	12	6

Resources:

- *A checklist that can be utilized as a proactive risk management and educational tool is available at http://www.in.gov/fssa/ddrs/2635.htm.*
- *http://www.npuap.org/resources/educational-and-clinical-resources/push-tool/*
- *http://www.mayoclinic.com/health/bedsores/DS00570*
- *http://ldhpmed.com/Explanation.php - explanation, prevention, bed-bound, wheelchair, shearing, and stages.*

Areas prone to pressure sores or decubitus for those who utilize wheelchairs (ldhpmed.com)



Dignity of Risk vs. Safety

Based on cases reviewed this quarter, the following issue was noted at least once and determined to be an issue that would be beneficial to share with providers, case managers, and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

The IDT for people who live independently/semi-independently need to identify a person's optimum living environment. Specific factors will vary based on each person. The team should assess the person's ability to respond to both day-to-day and emergency situations on their own. Options offered should take into account the person's physical and cognitive abilities to successfully evacuate a building or area on his/her own. Is a ground level unit in a high-rise building more appropriate? A rural versus urban area? A busy versus more residential setting? Is proximity to schools and/or parks an issue? Are there concerns about the person's physical and/or cognitive functioning? Do they have a diagnosis of dementia? Are they able to use a fire extinguisher? Can they see and/or hear if they are in a dangerous situation?

If there are safety issues, the team needs to think about ensuring the person's health and safety from all angles and in as many situations as possible. One of the challenges for the team of a higher-functioning person is to ensure freedom and rights are preserved, while also ensuring safety measures are in place for any identified areas of weakness.

Dignity of Risk vs. Safety (Cont.)

If a person lives independently/semi-independently, ongoing training should include successfully completing emergency evacuation drills without assistance. In addition, there should be continual education on safeguards to ensure safety in situations pertinent to the person (e.g., caution when opening the door, importance of locking the home/apartment, keeping personal information private, knowing the side effects of medications and who to call if a side effect is present, knowing who to call if/when bleeding occurs, etc.).

Providers who provide less than 24/7 hours are not "off-the-clock."

They are still responsible during the off-hours.

Quality Assurance / Quality Improvement Systems

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

Documentation

As part of the mortality review process, a wide variety of documents are examined and inconsistencies between documents are identified at times. With the multitude of people, documents, and processes involved in providing services/supports, inconsistencies will occur. It is recommended that providers examine and perform a crosswalk of the agency's documents on a regular basis to identify and rectify inconsistencies in the record. It is recommended that if an inconsistency is identified, a note is made regarding the inconsistency and what action was taken to address the inconsistency. At times, the updated version of a care plan or dining plan is not placed in the person's record or is removed and not replaced, and the staff then follow an outdated plan. It is important that all outdated plans are removed and the current plan is in place to guide staff.

A variety of examples and situations follow:

- Intake/output/dining tracking logs were reviewed in conjunction with staff notes. The log says the person ate 100% of a meal, but according to staff notes the person did not eat at all.
- Medications on the Medication Administration Record were signed off as being given; however, due to the person's condition, he/she was transported to the ER and the medications were not actually given.
- A review of the person's seizure logs, monthly/quarterly summaries, incident reports, etc. should reflect the same information regarding the number of seizures a person has had within a specific time period or comment on why there might be a discrepancy between documents.
- Identified inconsistencies between the information included in the ISP, risk plan, dining plan, etc. regarding the type of diet texture and/or liquid consistency a person is to receive. Depending on which document is referred to, the person could receive the incorrect texture/consistency putting the person at risk.
- Identified inconsistencies between the information included in the ISP, risk plan, fall prevention plan, etc. regarding strategies regarding fall prevention. Depending on which document is referred to, the outdated strategies could be utilized putting the person at risk.
- And an example that also involves information included in the ER/hospital discharge summary - the ER report indicates the person was lying on the bed when the EMTs arrived. The agency's documents indicate the person was on the floor. As part of the internal review of the death, discrepancies between the information in an ER/hospital discharge summary and the provider's documents should be identified and addressed.

Seizures

The provider should review (and update as appropriate) the agency's policy/procedure regarding seizures management tracking. If a person has seizures, the agency's process should ensure there is consistency between all documents (e.g., ISP, seizure logs, list of diagnoses, monthly/quarterly summaries, incident reports, etc.). Periodic lab levels should be obtained when a person is receiving seizure medication for which lab values are clinically useful in adjusting dosages. Lab levels are ordered by the PCP usually on a routine schedule/frequency and as necessary (e.g., when changing dosage, changing medication regimens, when seizures occur with

Quality Assurance / Quality Improvement Systems (Cont.)

increased frequency, etc.) The frequency, scheduling and results of these lab levels should be readily available to the team and others as appropriate. The agency's policy/procedure/process should clearly define who monitors the levels, how this review is documented and what actions are taken with the results.

Oversight of Home

The provider should review (and update as appropriate) the agency's policy/procedure/process regarding oversight of each home. Who (by role/title) monitors the oversight of the home? Are there unannounced visits on all shifts/days of the week? What issues are monitored (e.g., adaptive equipment, dining plans, implementation of risk plans, environmental health/safety items)? How is the oversight/monitoring documented? Does anyone aggregate the results to identify trends (e.g., types of issues, people who work in the homes, etc.) and take corrective action?

Recognizing and Responding to Change in Status

The provider should review (and update as appropriate the agency's policy/procedure regarding recognizing and responding to changes in status. Who does the DSP tell of a change in status and how quickly? Who takes the next step and how quickly? How often are staff trained on this topic? What is the agency's system to monitor?

G-/J-Tube

The provider should review (and update as appropriate) the agency's policy/procedure/process for verifying the correct route is listed on the prescription, physician's order, and medication administration record (MAR) for anyone with a G-, J-, G-/J-tube.

The provider should review (and update as appropriate) the agency's policy/procedure/process for taking, documenting, and monitoring vital signs (at least pulse and respirations) more frequently at first, and less frequently as the person heals for at least the first 30 days following tube placement.

A provider's quality assurance and quality improvement system is evaluated during a **CERT review**. Of the 133 providers reviewed with the CERT from 10/01/2012 through 09/30/2012, the following deficiencies were noted:

- Annual survey of satisfaction (conduct, analyze and use for improvement): Unmet by 24.8% of providers
- Appropriateness and effectiveness of a person's ISP: Unmet by 10.5% of providers
- Quality assurance and improvement efforts associated with reportable incidents: Unmet by 14.3% of providers
- Quality assurance and improvement efforts associated with medication errors: Unmet by 10.5% of providers
- Quality assurance and improvement efforts associated with behavioral supports: Unmet by 9.8% of providers

Summary and Final Remarks

A person's needs do not remain the same indefinitely. It is important for team members to have the knowledge to recognize the changes when they occur and to have the tools necessary to respond quickly and appropriately to reduce the risk. Each person's primary care physician/specialist is another excellent resource.

As part of the effort to improve the quality of services being delivered in Indiana, this communication is designed to enhance the dissemination of functional information that can be both understood and utilized back to providers, case managers, and other interested stakeholders.

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